

NOTICE OF ACTION

(Continued)

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

APPLICANT - FINANCIAL ELIGIBILITY TEST

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone: _____
Address : _____

You are ineligible because your **Net Countable Income** is more than your **Family Needs**.

Family's Total Earned Income (Assistance Unit +
Non-Assistance Unit Members) \$ _____
\$90 Disregard for each employed person - _____
Other Nonexempt Income (Assistance Unit +
Non-Assistance Unit Members) + _____
Net Countable Income = _____

Family Needs

Basic Need for _____ Persons (Assistance Unit +
Non-Assistance Unit Members) \$ _____
Special Needs (Assistance Unit + Non-Assistance
Unit Members) + _____
Family Needs = _____

Rules: These rules apply; you may review them at your welfare office:
MPP 44-207.1

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of page 1 tells how.